



UNIVERSITY GASTROENTEROLOGY, P.C.

1928 Alcoa Highway, B-100 Knoxville, Tennessee 37920

Phone 865-305-6570 Fax 865-305-6576

SCREENING COLONOSCOPY

Your physician recommends that you undergo a colonoscopy procedure to screen for colon cancer.

- The *American Cancer Society* recommends a colonoscopy for everyone 50 years of age and older.
- A colonoscopy may be recommended earlier if you have a family member with a history of colon cancer.
- A colonoscopy *significantly reduces* your lifetime risk of colon cancer.

University Gastroenterology is dedicated to providing you with the best care and service possible. Our experienced scheduling assistants are available to walk you through the entire screening process. They can answer any questions or concerns you may have while letting you know what you can expect before, during and after your procedure. They will work closely with your insurance company to identify your individual coverage and will communicate any potential coverage issues prior to your appointment.

- You may hand deliver this packet to our office anytime during normal business hours. At that time a scheduling assistant will meet with you one on one to answer questions and walk you through the rest of the process. Complimentary parking is available.
- You may mail it to our office along with a current copy of your insurance card(s) to:

University Gastroenterology
1928 Alcoa Highway B-100
Knoxville, TN 37920

- You may fax it to our office along with a current copy of your insurance card(s) to:

865-305-6576

Our dedicated physicians and friendly staff look forward to providing you with exceptional patient care.

University Gastroenterology, PC
Patient Registration

PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____ MAILING ADDRESS _____
FIRST NAME _____ MIDDLE _____ CITY _____ STATE _____ ZIP _____
LAST NAME _____ HOME (_____) _____ WORK (_____) _____
SEX _____ DATE OF BIRTH _____ CELL (_____) _____
MARITAL STATUS _____ FAMILY DOCTOR _____
 MARRIED SINGLE DIVORCED WIDOWED
NAME OF REFERRING PHYSICIAN _____
EMPLOYMENT STATUS _____ EMPLOYER _____
 EMPLOYED RETIRED FULL TIME STUDENT OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE _____ CARD HOLDER'S NAME _____
RELATIONSHIP _____ DOB _____ SOC. SEC. # _____
SECONDARY INSURANCE _____ CARD HOLDER'S NAME _____
RELATIONSHIP _____ DOB _____ SOC. SEC. # _____

EMERGENCY CONTACT

RELATIONSHIP _____ SEX _____
FIRST NAME _____ LAST NAME _____
HOME (_____) _____ WORK (_____) _____ CELL (_____) _____

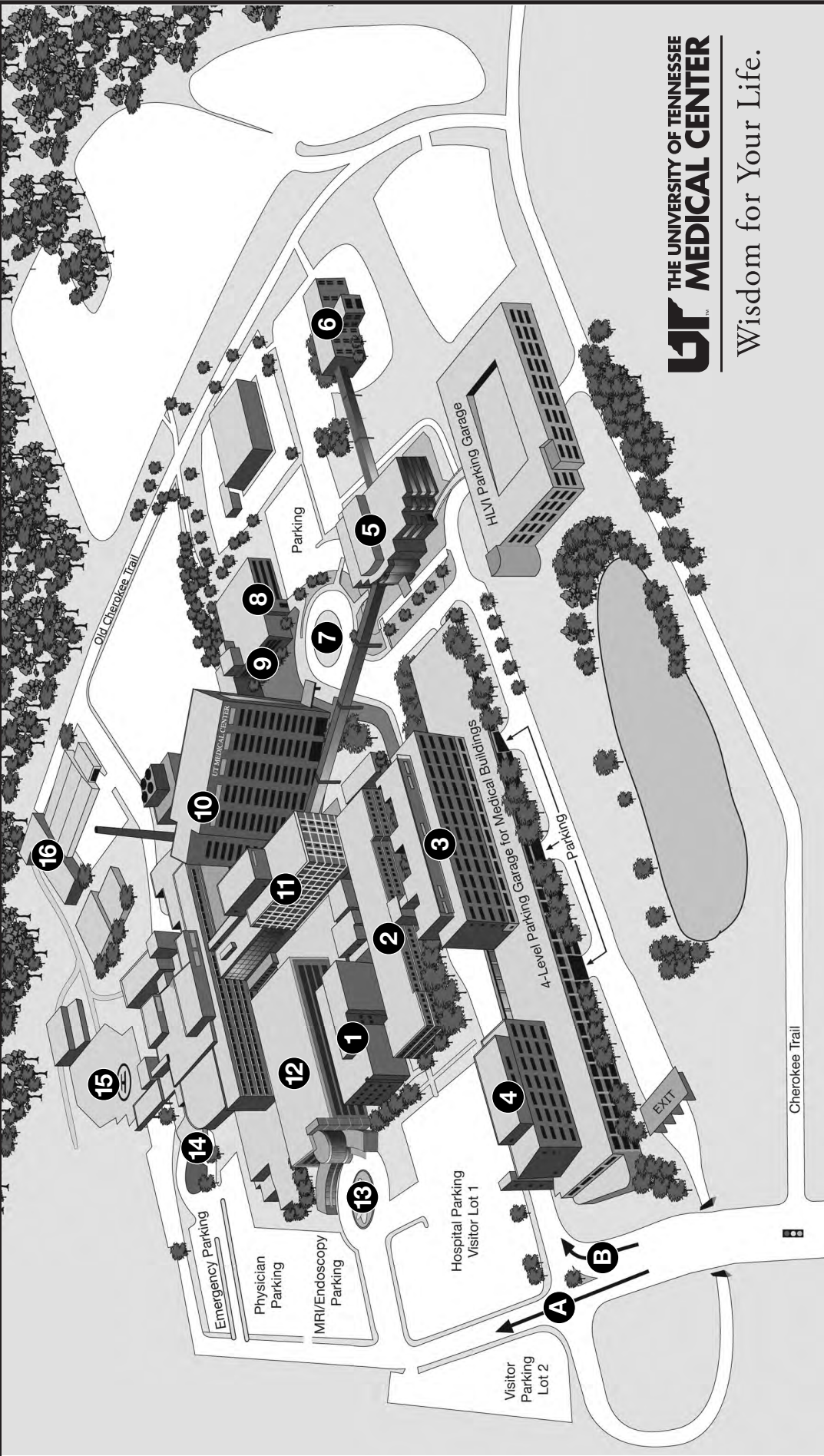
CONTACT INFORMATION

PHARMACY _____ PHARMACY NUMBER (_____) _____
University Gastroenterology will leave **confidential messages** on your answering machine, with a family member or other individual answering the phone when you are not at home unless you indicate otherwise. We will safeguard your privacy by limiting the amount of information disclosed. For example, when calling your home we will only leave our name and number and other information necessary to confirm an appointment, or ask you call back.
Please contact me as follows:
HOME TELEPHONE (_____) _____ WORK TELEPHONE (_____) _____
 OK to leave messages with healthcare information OK to leave messages with healthcare information.
 Leave message with call back number only. Leave message with call back number only.
 Do NOT leave messages Do NOT leave messages
 Retired or not working
LIST NAME OF INDIVIDUALS YOU AUTHORIZE US TO SPEAK WITH REGARDING YOUR HEALTHCARE.
 None Other _____
 Spouse _____ Other _____
 Child _____

If we are unable to reach you by any other means, we will send information through the U.S. Postal Service to your home address.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I Hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) _____ DATE _____



**UT THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER**

Wisdom for Your Life.

Route A: To Hospital and Emergency Dept.

Route B: To Physician Offices and East Circle

- 1. Medical Building A
- 2. Medical Building B
- 3. Medical Building C
- 4. Brain and Spine Institute
- 5. Cancer Institute
- 6. Medical Building E
- 7. Heart Lung Vascular Institute
- 8. Cherokee Trail Building

7. East Circle

- 8. Patient Drop-Off and Pick-Up
- 9. College of Pharmacy
- 10. Graduate School of Medicine
- 11. Boling Patient Pavilion
- 12. South Pavilion
- 13. Heart Hospital
- 14. Under Construction, Opening 1020
- 15. Emergency/Trauma
- 16. LIFESTAR
- 17. Human Resources

DIRECTIONS TO UNIVERSITY GI

Driving directions from either I-40 East or West: Take the 129 (Alcoa Highway) exit. Travel south on 129 approximately one mile to the UT Medical Center/Cherokee Trail exit. Follow the exit onto the Medical Center campus and follow the signs for Physician Office Buildings. We are located in building B, Suite 100.

Driving directions from the airport: Take the Knoxville exit from the airport. This will take you to Alcoa Highway (north 129). Travel on Alcoa Highway (north 129) for approximately 10 miles and exit right at the Medical Center/Cherokee Trail exit. Follow the signs for Physician Office Buildings and we are located in building B, Suite 100.

University Gastroenterology, P.C.

1928 Alcoa Highway B-100

Knoxville, TN 37920

P 865-305-6570

F 865-305-6576

Please read and sign in space provided below. A copy of this can be provided to you upon request.

We recognize the need for a definite understanding between the patient and the doctor concerning health care and the financial arrangements for this medical care. Our commitment is to provide the very best health care for our patients while recognizing the need to limit services to only those that are necessary for each patient.

Our fees reflect the time spent by the doctor with you, the patient, the specialized nature of the doctor's training, and the individual diagnostic studies performed. Our fees are comparable to other similarly trained specialists in the community.

If you are scheduling a screening colonoscopy, or find that you are in need of one in the future, please understand that the pre-certification we get from your insurance company is only a guideline that you can use. If our physician finds that you need a polyp removed during the procedure he will remove it. In this case, this will change your screening to a diagnostic procedure which could possibly cause your insurance company to pay less than originally stated. Of course, the fees for care during a specialized procedure or hospitalization may be paid on any mutually agreeable basis. Please contact your insurance company with any additional questions you might have concerning your procedure.

Please let us know if you are having any particular financial problem - you will find us understanding and patient.

I have read and understand the above.

Signature _____ **Date** _____

University Gastroenterology, P.C.

Payment Policy

We are committed to providing you with quality and affordable healthcare. Please read the below and ask any questions you may have, and sign in the space provided.

1. Insurance Plans. We are providers with Medicare, most Aetna plans, Americhoice, Beech Street, Blue Cross Blue Shield of Tennessee, Blue Care, Bowater, Cariten, Humana, Champus- military only, CIGNA, The Initial Group, Preferred Health Partnership (PHP) and United Healthcare. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.

2. Co-payments. **All co-payments must be paid at check-in.** This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.

3. Referrals. Many patients are now required to obtain referrals or authorizations from their primary care physician (PCP) before receiving treatment from a specialist. It is important that you obtain this from your PCP before coming in for your appointment. Our fax # is 865-305-6576.

4. Non-Covered Services. Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit with your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item.

5. Proof of Insurance. All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once every year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.

6. Claim Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any moneys owed after we have received payment from Medicare and/or a secondary policy that you might have.

7. Non-payment. If your account is over 90 days past due, you will receive a letter from our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. HIPPA. A copy of the UPA Notice of Information Practices has been made available to me. I understand that this notice describes how my health information may be used or disclosed by UPA, physicians and other providers practicing at UPA facilities and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling 865-544-9118, by visiting www.utmedicalcenter.org or by requesting one from the UPA office.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient signature _____ Date _____

A copy of this can be provided to you upon request.

UNIVERSITY GASTROENTEROLOGY, P.C.

Dr. Mark D. Anderson

Dr. John A. Stancher

Dr. Sangeeta(Sandy)Gulati

Dr. Carlos Rollhauser

Dr. Ramanujan Samavedy

1928 Alcoa Hwy, Bldg B, Suite 100, Knoxville, TN 37920

Phone (865) 305-6570 Fax (865) 305-6576

Last Name

First Name

MI

Birthdate

Social Security Number

Have you ever been treated/scoped by any other Gastroenterologist anywhere in the past? If so,

Who? _____ Where? _____ When? _____

If you have a preference, please circle the doctor that you would like to see:

Dr. Mark Anderson

Dr. John Stancher

Dr. Sandy Gulati

Dr. Carlos Rollhauser

Dr. Ramanujan Samavedy

No preference

Please indicate any dates that you will NOT be available _____

PAST MEDICAL HISTORY

Check all that apply: Personal History of Colon Cancer or Polyps? If so, when _____
 Family History of Colon Cancer Who? _____
 Family History of Colon Polyps Who? _____

Change in Bowel Habits

Rectal Bleeding

Abdominal Pain

Heart Disease

Heart Valve Disease

Bleeding/Clotting Disorder

Diabetes _____

Hypertension

Sleep Apnea/CPAP machine

Renal Disease

Artificial Hips and/or knees

Transplant

Oxygen

Rheumatic Fever

Pacemaker/Defibrillator, Valves or Stents

Endocarditis

Recent Bypass within the last year

LIST OF ALL MEDICATIONS AND DOSE:

Are you currently taking Coumadin, Plavix (blood thinners) or daily aspirin? YES NO

MEDICATION ALLERGIES: _____

PREVIOUS SURGERIES _____

REFERRING PHYSICIAN _____ PHONE _____

PLEASE SEND COPIES, FRONT AND BACK, OF ALL YOUR INSURANCE CARDS

● Destination/
Function

ℹ Information

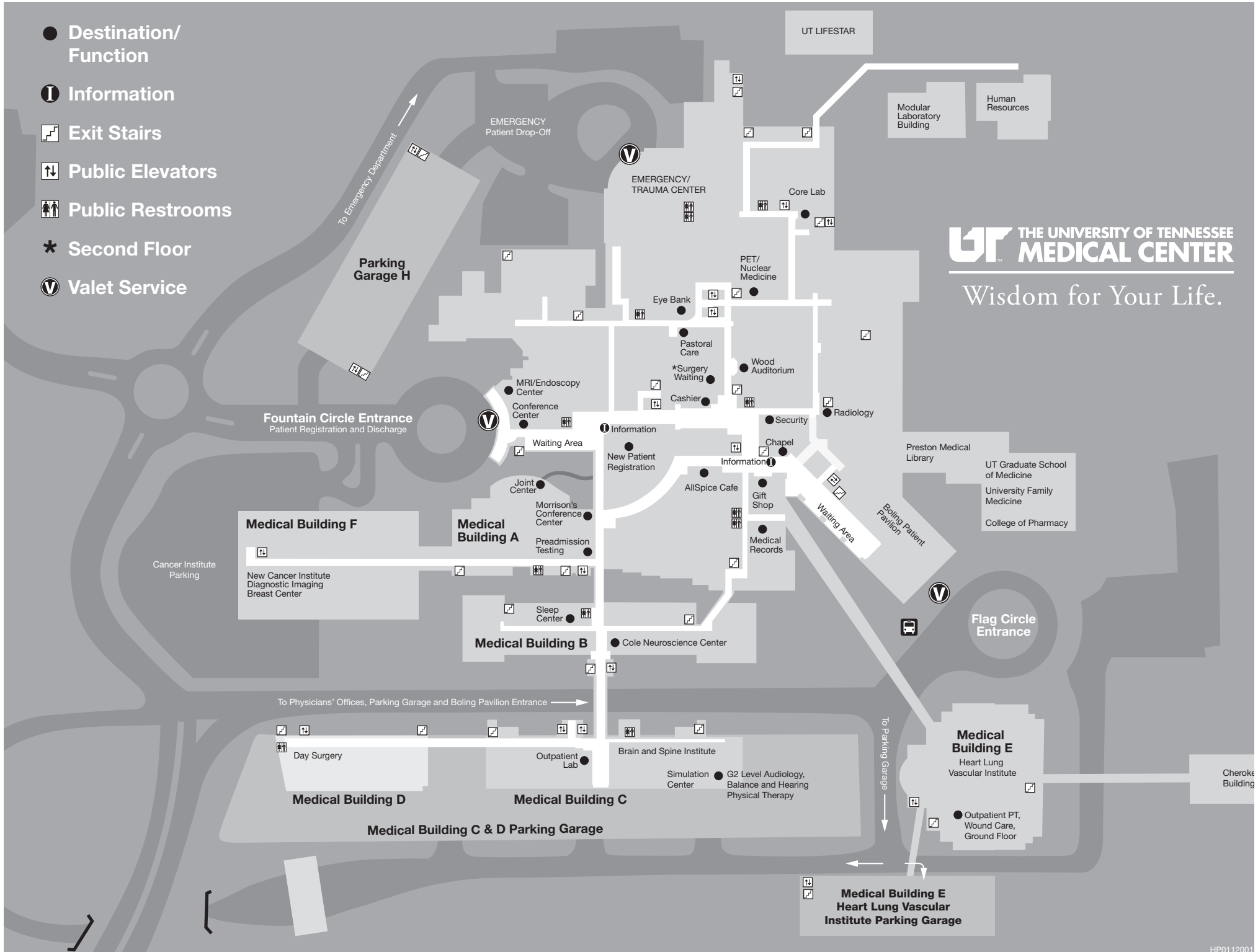
Exit Stairs

Public Elevators

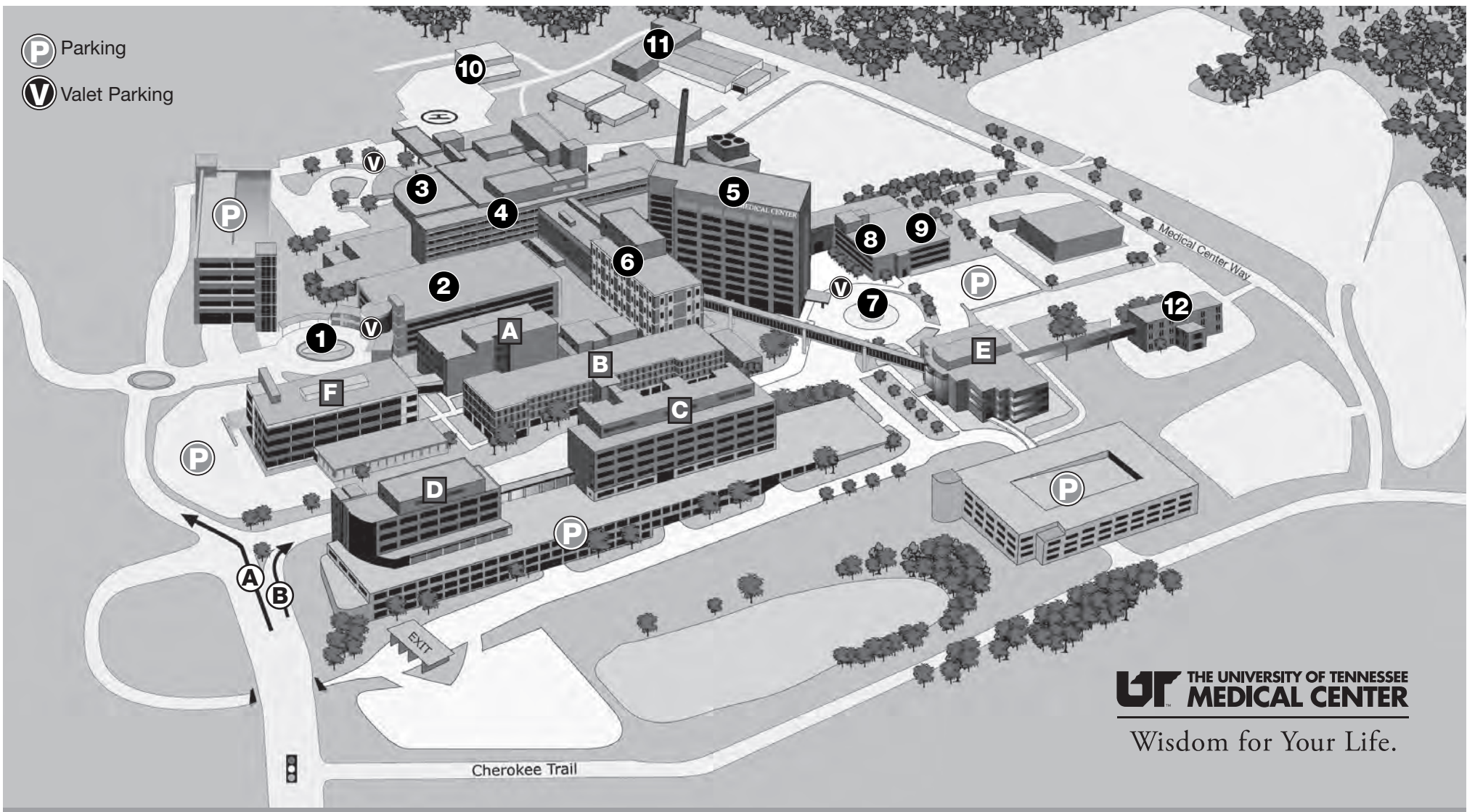
Public Restrooms

* Second Floor

Ⓥ Valet Service



**UT THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER**
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P Parking
V Valet Parking

Route A: To Hospital/Main Entrance, Parking Garage, Emergency Dept, MRI, Endoscopy and Cancer Institute

Route B: To Medical Offices and Parking Garage

- 1** Fountain Circle
- 2** Heart Hospital, Endoscopy Center, MRI
- 3** Emergency/Trauma
- 4** North Tower
- 5** Boling Patient Pavilion

- 6** South Pavilion
- 7** Flag Circle
- 8** UT Graduate School of Medicine
University Family Medicine
- 9** UT College of Pharmacy
- 10** UT LIFESTAR
- 11** Human Resources/
Facilities Planning
- 12** Cherokee Trail Building

Medical Office Buildings

- A** Medical Building A
- B** Medical Building B
- C** Medical Building C-Brain and Spine Institute
- D** Medical Building D-UT Day Surgery
- E** Medical Building E-Heart Lung Vascular Institute
- F** Medical Building F-New Cancer Institute

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